DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-10

2. STATE: VIRGINIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
OCTOBER 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 440

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ 2,519,000
b. FFY 02 $ 2,244,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1 A&B, Supp. 1, pp 4.1, 4.1.1, 4.2, 4.3, 4.4 and 28 of 41;

Attachment 3.1 E, pp 5-11 of 11.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Atch 3.1E pp 5-9

SUPP 1 to ATCH 3.1 A+B 4.1, 4.1.1, 4.2, 4.3, 4.4, 27.1

10. SUBJECT OF AMENDMENT:
Expansion of Organ Transplant Coverage; Coverage of Colorectal Cancer Screening.

GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary of Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dennis G. Smith

14. TITLE:
Director

15. DATE SUBMITTED:
12/12/2000

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad St., Suite 1300
Richmond, VA 23219

ATTN: Reg. Coor.

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12/22/00

18. DATE APPROVED:
JANUARY 30, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/00

20. SIGNATURE OF REGIONAL OFFICIAL:
Claudette V Campbell

21. TYPED NAME:
CLAUDETTE V CAMPBELL

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIV OF MEDICAID & STATE OPERATIONS

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

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D. Screening services for colorectal cancer, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

13c. Preventive services.

A. Maternity length of stay and early discharge.

1. If the mother and newborn, or the newborn alone, is discharged earlier than 48 hours after the day of delivery, DMAS will cover one early discharge follow-up visit as recommended by the physicians in accordance with and as indicated by the "Guidelines for Perinatal Care" as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (1992, as amended). The mother and newborn, or the newborn alone, if the mother has not been discharged, must meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge follow-up visit does not affect or apply to any usual postpartum or well-baby care or any other covered care to which the mother or newborn is entitled; it is tied directly to an early discharge.

2. The early discharge follow-up visit must be provided as directed by a physician. The physician may coordinate with the provider of their choice to provide the early discharge follow-up visit, within the following limitations. Qualified providers are those hospitals, physicians, nurse midwives, nurse practitioners, federally qualified health clinics, rural health clinics, and health departments clinics that are enrolled as Medicaid providers and are qualified by the appropriate state authority for delivery of the service. The staff providing the follow-up visit, at a minimum, must be a registered nurse having training and experience in maternal and child health. The visit must be provided within 48 hours of discharge.

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E. Hospital claims with an admission date prior to the first surgical date, regardless of the number of days prior to surgery, must be medically justified. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for all pre-operative days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

F. Reimbursement will not be provided for weekend (Saturday/Sunday) admissions, unless medically justified. Hospital claims with admission dates on Saturday or Sunday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admission will be denied.

G. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60-day period for the same or similar diagnosis and/or treatment plan. The 60 day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60-day period. Claims which exceed 21 days per admission within 60 days, for the same or similar diagnosis, and/or treatment plan, will not be reimbursed. Claims which exceed 21 days per admission within 60 days, with a different diagnosis and/or treatment plan, will be considered for reimbursement, if medically justified. The admission and length of stay

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must be medically justified and preauthorized via the admission and concurrent review processes described described in Subsection A of 12 VAC 30-50-100. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease with dates of service on or after July 1, 1998. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary hospitalizations in excess of 21 days per admission when such services re rendered for the purpose of diagnosis and treatment of conditions identified through a physical or psychological/psychiatric examination.

H. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate.

I. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the DMAS-outpatient surgery list unless the inpatient admission is medically justified or meets one of the exceptions.

J. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart and bone marrow/stem cell transplants and any other medically necessary transplantation

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procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, hear and bond marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee does not include pre-and post-hospitalization for the transplant procedure or pre-transplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are preformed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplant is a the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12 VAC 30-50-540 through 12 VAC 30-50-570.

K. Coverage of observation beds. *Reserved.*

L. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed, shall be subject to review of the required DMAS forms corresponding to the beforementioned procedures. The claims shall suspend for manual review by

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9. In addition to hospital administration and medical staff endorsement, hospital staff support also exists for such a program;

10. Initial approval as CT center requires performance of corneal transplant surgery, with a one year graft survival rate of at least 75%. Centers that fail to meet this requirement during the first year will be given a one-year conditional approval. Failure to meet this requirement following the conditional approval will result in loss of approval.

§3.1. Liver, heart, lung, allogeneic and autologous bone marrow transplantation. (12VAC30-50-560)

Patient selection criteria for provision of liver, heart, allogeneic and autologous bone marrow transplantation

1. The following general conditions shall apply to these services:

   a. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis.

   b. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable.

   c. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective.

   d. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS.

2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement:

   The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be pre-authorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by DMAS of information submitted by the transplant team or center.

   The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

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a. Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;

b. The patient is not in an irreversible terminal state, and

c. The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

§3.2 Facility selection criteria for liver, heart, allogeneic and autologous bone marrow transplantation.

1. The following general conditions shall apply:

   a. Procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant can not be performed in the necessary time period.

   b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.

2. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

   a. The transplant program staff has demonstrated expertise and experience in the medical and surgical treatment of the specific transplant procedure;

   b. The transplant surgeons have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;

   c. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

   d. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;

   e. Adequate blood bank support services are available;

   f. Adequate arrangements exist for donor procurement services;

   g. Current full membership in the United Network for Organ Sharing, for the facilities where solid organ transplants are performed;

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h. Membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

i. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

j. Transplant volume at the facility is consistent with maintaining quality services;

k. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

§3.3. High dose chemotherapy and bone marrow/stem cell transplantation (coverage for persons over 21 years of age). (12VAC30-50-570).

A. Patient selection criteria for high dose chemotherapy and bone marrow/stem cell transplantation (coverage for persons over 21 years of age).

1. The following general conditions shall apply to these services:

a. This must be the most effective medical therapy available yielding outcomes that are at least comparable to other therapies. 12VAC30-50-570. 12VAC30-50-570. 12VAC30-50-570.

b. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective.

c. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS. The nearest approved and appropriate facility will be considered.

2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement for individuals who have been diagnosed with lymphoma, breast cancer , leukemia, or myeloma and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high dose chemotherapy and bone marrow/stem cell transplant:

a. The patient selection criteria of the transplant center where the treatment is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be preauthorized only if the selection of the patient adheres to the transplant center's patient selection criteria based upon review by DMAS of information submitted by the transplant team or center.

b. The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

(1) The patient is not in an irreversible terminal state (as demonstrated in the facility's patient selection criteria); and

(2) The transplant is likely to prolong life and restore a range of physical and social functions suited to activities of daily living.

B. Facility selection criteria for high dose chemotherapy and bone marrow/stem cell transplantation for individuals diagnosed with lymphoma, breast cancer, leukemia, or myeloma.

1. The following general conditions shall apply:

a. Unless it is cost effective and medically appropriate, procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant cannot be performed in the necessary time period.

b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities

2. To qualify for coverage, the facility must meet, but not necessarily be limited to, the following criteria:

a. The transplant program staff has demonstrated expertise and experience in the medical treatment of the specific transplant procedure;

b. The transplant physicians have been trained in the specific transplant technique at an institution with a well established transplant program for the specific procedure;

c. The facility has expertise in immunology, infectious disease, pathology, pharmacology, and anesthesiology;

d. The facility has staff or access to staff with expertise in tissue typing, immunological and immunosuppressive techniques;

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e. Adequate blood bank support services are available;

f. Adequate arrangements exist for donor procurement services

g. The facility has a membership in a recognized bone marrow accrediting or registry program for bone marrow transplantation programs;

h. The transplant facility or center can demonstrate satisfactory transplantation outcomes for the procedure being considered;

i. Transplant volume at the facility is consistent with maintaining quality services; and

j. The transplant center will provide adequate psychosocial and social support services for the transplant recipient and family.

§3.4. Other medically necessary transplantation procedures that are determined to not be experimental or investigational (coverage for persons younger than 21 years). (12VAC30-50-580).

A. Patient selection criteria for any other medically necessary transplantation procedures that are determined to not be experimental or investigational.

1. The following general conditions shall apply to these services:

a. Coverage shall not be provided for procedures that are provided on an investigational or experimental basis.

b. There must be no effective alternative medical or surgical therapies available with outcomes that are at least comparable.

c. The transplant procedure and application of the procedure in treatment of the specific condition for which it is proposed have been clearly demonstrated to be medically effective and not experimental or investigational.

d. Prior authorization by the Department of Medical Assistance Services (DMAS) is required. The prior authorization request must contain the information and documentation as required by DMAS.

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2. The following patient selection criteria shall apply for the consideration of authorization and coverage and reimbursement:

a. The patient must be under 21 years of age at time of surgery.

b. The patient selection criteria of the transplant center where the surgery is to be performed shall be used in determining whether the patient is appropriate for selection for the procedure. Transplant procedures will be pre-authorized only if the selection of the patient adheres to the transplant center's patient selection criteria, based upon review by DMAS of information submitted by the transplant team or center.

The recipient's medical condition shall be reviewed by the transplant team or program according to the transplant facility's patient selection criteria for that procedure and the recipient shall be determined by the team to be an appropriate transplant candidate. Patient selection criteria used by the transplant center shall include, but not necessarily be limited to, the following:

(1) Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management;

(2) The patient is not in an irreversible terminal state, and

(3) The transplant is likely to prolong life and restore a range of physical and social function suited to activities of daily living.

B. Facility selection criteria.

1. The following general conditions shall apply:

a. Procedures may be performed out of state only when the authorized transplant cannot be performed in the Commonwealth because the service is not available or, due to capacity limitations, the transplant can not be performed in the necessary time period.

b. Criteria applicable to transplantation services and centers in the Commonwealth also apply to out-of-state transplant services and facilities.

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consultation with the patient determines that a shorter period of hospital stay is appropriate.

6. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

7. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow transplant/stem cell services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures

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performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12 VAC 30-50-540 through 12 VAC 30-50-570.

8. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review. Hospitals must submit the required DMAS forms corresponding to the procedures. Regardless of authorization for the hospitalization during which these procedures were performed, the claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

12 VAC 30-50-105. Non Cost Reporting Providers. (Non-participating/out of state).

A. Inpatient hospital services, when rendered by non-cost reporting providers, shall not require preauthorization with the exception of transplants as described in subsection 10 below. Inpatient hospital services claims will be suspended from payment and manually reviewed for medical necessity as described in subsections 2-10 below using criteria specified by DMAS until such time as DMAS implements full DRG payment methodology. As such time, all inpatient hospital services claims from non-cost reporting providers will suspend from payment and shall be manually reviewed for medical necessity of the admission for non-psychiatric hospital stays and for medical necessity for the admission and length of stay for psychiatric hospital stays using criteria as designated by DMAS.

B. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under four days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed three days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection seven of this section.) Inpatient hospital services will be reviewed for appropriateness of the admission and length of stay.

C. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

D. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.